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Issue date: 18Apr2002

CASE No.: 2001-BLA-00223

In the Matter of:

CLARENCE F. POLUKIS,
Claimant

v.

READING ANTHRACITE COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances: Helen M. Koschoff, Esquire
For Claimant

Frank L. Tamulonis, Jr., Esquire
For Employer

Before: ROBERT D. KAPLAN
Administrative Law Judge

DECISION AND ORDER
DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901–945 (the Act) and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[1]

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis.

[1]Unless otherwise noted, the regulations cited are the revised regulations, effective January 19, 2001, found at 20 C.F.R. § 718, et. seq. (2000).

Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

On December 1, 2000, this case was referred to the Office of Administrative Law Judges for a formal hearing. Subsequently, the case was assigned to me. The hearing was held before me in Wilkes-Barre, Pennsylvania on September 11, 2001, where the parties had full opportunity to present evidence and argument. The following exhibits were submitted post-hearing and pursuant to my ruling at the hearing are now admitted into evidence: the X-ray reports of Drs. Ahmed, Cappiello, and Miller, and two reports by Dr. Venditto and Dr. Simelaro validating the August 14, 2001 pulmonary function study.[2] (CX 21)[3] Employer filed a brief on December 28, 2001. Claimant did not submit a brief. This decision is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

The parties stipulated that Claimant had 43 years of coal mine employment. (T 20). Therefore, the issues presented for resolution are:

1. Whether Claimant has pneumoconiosis as defined by the Act and regulations; and

2. whether Claimant's pneumoconiosis arose out of coal mine employment; and

3. whether Claimant is totally disabled; and

4. whether Claimant's disability is due to pneumoconiosis.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

Claimant filed the instant initial claim for benefits on April 11, 2000. (DX 1) The District Director denied the claim on October 4, 2000, finding that Claimant had established no elements of entitlement. (DX 14) Claimant requested a formal hearing on October 6, 2000. (DX 15)

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[2]At the hearing, in response to Claimant's specific request, I ruled that Claimant was permitted to submit two validations of the August 14, 2001 pulmonary function study in addition to a report by Dr. Kraynak. (T 13) Claimant submitted a third validation, that of Dr. Prince, marked "CX 22." This is not received into evidence at this time as its submission is contrary to my ruling at the hearing.

[3]The following abbreviations are used herein: "CX" refers to Claimant's Exhibit; "DX" refers to Director's Exhibit; "EX" refers to Employer's Exhibit; and "T" refers to the transcript of the September 11, 2001 hearing.

B. Factual Background

Claimant was born on February 26, 1924. (DX 4; T 23) He has a 12th grade education. (DX 1) He married Anna Martusky Polukis on June 30, 1951. She is his sole dependent for purposes of augmentation of benefits under the Act. (DX 5; T 23)

Claimant testified that he has experienced problems breathing for the last three years. The problem is worse when walking on an incline. Claimant has been treated by both Dr. Kraynak and Dr. Langon for his breathing problems. (T 29–30) Claimant testified that he worked in coal mines as a shuttle operator, working above ground. (T 25–26, 34) His job involved climbing, repair work, and lifting weights of 100 pounds. (T 25–26) Claimant worked in coal mine employment until 1999 when he quit because he had developed carpal tunnel syndrome. (T 32) He testified that he periodically smoked approximately ½ pack of cigarettes a day over a 40–50 year period. (T 38–39)

C. Entitlement

Because this claim was filed after the enactment of the Part 718 regulations, Claimant's entitlement to benefits will be evaluated under Part 718 standards. §718.2. In order to establish entitlement to benefits under Part 718, Claimant must prove that he has pneumoconiosis, that it arose out of his coal mine employment, and that the pneumoconiosis has caused him to be totally disabled.

1. Presence of Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at § 718.202(a)(1) through (a)(4):

a. X-ray evidence. §718.202(a)(1).

b. Biopsy or autopsy evidence. §718.202(a)(2).

c. Regulatory presumptions. §718.202(a)(3).

(1) §718.304 – Irrebuttable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.

(2) §718.305 – Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment.

(3) §718.306 – Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30,1971.

d. Physician's opinions based upon objective medical evidence. § 718.202(a)(4).

The U.S. Court of Appeals for the Third Circuit has held that, in considering whether the presence of pneumoconiosis has been established, "all types of relevant evidence must be weighed together to determine whether the claimant suffers from the disease." Penn Allegheny Coal Co. v. Williams, 114 F.3d 22 (3d Cir. 1997).[4]

X-ray evidence, § 718.202(a)(1)

Under § 718.202(a)(1) the existence of pneumoconiosis can be established by chest X-rays conducted and classified in accordance with § 718.102. The record contains the following X-ray interpretations.[5]

DATE OF X-RAY	DATE READ	EX. NO.	PHYSICIAN	RADIOLOGICAL CREDENTIALS	I.L.O. CLASSIFICATION
09/26/95	09/26/95	DX 24	Scott	—	Negative
10/29/98	10/30/98	DX 24	Conrad	BCR, B[6]	2/2
08/23/00	08/24/00	DX 12	Kraynak	—	1/2
08/23/00	09/17/00	DX 13	Navani	BCR, B	Negative
08/23/00	10/20/00	DX 25	Duncan	BCR, B	Negative
08/23/00	10/23/00	DX 25	Laucks	BCR, B	Negative
08/23/00	10/23/00	DX 25	Soble	BCR, B	Negative
08/23/00	02/01/01	CX 2, 5	Ahmed	BCR, B	1/0
08/23/00	02/08/01	CX 3, 6	Cappiello	BCR, B	1/1

[4]This case comes within the jurisdiction of the Third Circuit because Claimant's coal mine employment took place in Pennsylvania.

[5]A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. § 37.51. A physician who is Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii).

[6]Credentials obtained from www.abms.org and www.oalj.dol.gov.

DATE OF X-RAY	DATE READ	EX. NO.	PHYSICIAN	RADIOLOGICAL CREDENTIALS	I.L.O. CLASSIFICATION
08/23/00	02/15/01	CX 4, 7	Miller	BCR, B	1/0
01/11/01	05/23/01	EX 4	Duncan	BCR, B	Negative
01/11/01	05/30/01	EX 5	Soble	BCR, B	Negative
01/11/01	06/01/01	EX 6	Laucks	BCR, B	Negative
01/11/01	09/26/01	CX 21, 5	Ahmed	BCR, B	1/0
01/11/01	09/27/01	CX 21, 6	Cappiello	BCR, B	1/0
01/11/01	10/01/01	CX 21, 7	Miller	BCR, B	1/0

It is well-established that the interpretation of an X-ray by a B-reader may be given additional weight by the fact finder. Aimone v. Morrison Knudson Co., 8 BLR 1-32, 34 (1985); Martin v. Director, OWCP, 6 BLR 1-535, 537 (1983); Sharpless v. Califano, 585 F.2d 664, 666–67 (4th Cir. 1978). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a B-reader as well as a Board-certified radiologist may be given more weight than that of a physician who is only a B-reader. Scheckler v. Clinchfield Coal Co., 7 BLR 1-128, 131 (1984). In addition, the judge is not required to accord greater weight to the most recent X-ray evidence of record, but rather, the length of time between the x-ray studies and the qualifications of the interpreting physicians are factors to be considered. McMath v. Director, OWCP, 12 BLR 1-6 (1988); Pruitt v. Director, OWCP, 7 BLR 1-544 (1984). Gleza v. Ohio Mining Co., 2 BLR 1-436 (1979).

Looking at the X-ray evidence as a whole, I find that it is in equipoise, as there are as many negative as positive interpretations by physicians who are both Board-certified radiologists and B-readers. In viewing the most recent X-rays in isolation (those taken in January 2001 and August 2000), I find that the scale tips in favor of Employer, as Dr. Kraynak's positive finding is entitled to minimal weight and the negative interpretations essentially outweigh the positive. Based on the foregoing, I find that the X-ray evidence does not support a finding of pneumoconiosis.

Biopsy or autopsy evidence, § 718.202(a)(2)

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is unavailable here, because the current record contains no such evidence.

Regulatory presumptions, § 718.202(a)(3)

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy or equivalent evidence of complicated pneumoconiosis, a condition not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. § 718.305(e). Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these

presumptions is applicable, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

Physicians' opinions, § 718.202(a)(4)

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth as follows in subparagraph (a)(4):

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgement, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Section 718.204(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" and "includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis." Section 718.201(a)(1) and (2) defines clinical pneumoconiosis and legal pneumoconiosis. Section 718.201(b) states:

> [A] disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

Because the physicians considered pulmonary function and arterial blood gas studies in determining the presence of pneumoconiosis, the results of these studies are summarized below. As there are numerous invalidations and validations of the pulmonary function studies and the physicians who provided opinions in this case relied in part on these tests, I first determine the validity of these tests and then address the respective physician opinions.

DATE	EX. NO.	PHYSICIAN	AGE	FEV1	FVC	MVV	FEV1/ FVC	EFFORT	QUALIFIES
10/29/98	DX 24	Ahluwalia	74	2.92	4.06	86	72%	Good	No
08/23/00	DX 6	R. Kraynak	76	0.91 1.37*	1.72 2.99*	19 28*	52% 45%*	Good Good*	Yes Yes*
01/11/01	EX 15	Levinson	76	2.56 2.78*	2.75 3.24*	76 59*	9% 83%*	Poor Poor*	No No*
02/26/01	CX 8	M. Kraynak	77	1.09 1.51*	1.65 2.12*	58 57*	66% 71%*	Good Good*	Yes Yes*

DATE	EX. NO.	PHYSICIAN	AGE	FEV1	FVC	MVV	FEV1/ FVC	EFFORT	QUALIFIES
08/14/01	CX 13	R. Kraynak	77	1.61	2.80	75	60%	Good	Yes

* post-bronchodilator

August 23, 2000 Pulmonary Function Study

Dr. Sander Levinson (Board-certified in Internal Medicine and Pulmonary Disease) reviewed the tracings of the August 23, 2000 pulmonary function study and in a report of September 25, 2000 invalidated this study. (DX 7) He noted poor effort and "excessive variability of FEV1's [sic]." (DX 7) On November 13, 2000, Dr. Levinson reviewed the tracings again and reiterated this opinion, noting that the variability was greater than 500 mls., in excess of the variability permitted by the regulations. (EX 7) In a report of January 4, 2001, Dr. Raymond Kraynak (Board-eligible in Family Practice) countered that the MVVs showed good effort, and that the variability in FEV1 was less than 100ml. (CX 1) I find that Dr. Levinson's report is entitled to more weight than Dr. Kraynak's report because of the former physician's superior credentials. Based on the foregoing, I find that the August 23, 2000 pulmonary function study is not valid.

January 11, 2001 Pulmonary Function Study

In a report dated June 20, 2001, Dr. John P. Simelaro (Board-certified in Internal Medicine and Medical Diseases of the Chest) invalidated the January 11, 2001 pulmonary function test stating that there was "too much variation in spirometers." (CX 16, 17) In a report dated June 21, 2001, Dr. Michael A. Venditto (Board-certified in Internal Medicine and Medical Diseases of the Chest) invalidated the January 11, 2001 for the same reason. (CX 18, 19) In his report of March 27, 2001, Dr. Levinson acknowledged that Claimant used "very poor effort" in this study. However, given that pulmonary function tests are effort-dependent, and spuriously low values are possible but spuriously high values are not, this study would still tend to be a more reliable indicator of Claimant's current lung function than the August 23, 2000 study that preceded it. See Andruscavage v. Director, OWCP, No. 93-3291, slip op. at 9–10 (3d Cir., February 22, 1994) ("medical literature supports...the conclusion that [pulmonary function studies] which return disparately higher values tend to be more reliable indicators of an individual's respiratory capacity than those with lower values"). For this reason, I find that the January 11, 2001 pulmonary function study has some probative value.

February 26, 2001 Pulmonary Function Study

Dr. Levinson invalidated the February 26, 2001 pulmonary function study in a report of March 20, 2001. (EX 8) He found "marked and excessive variability" between the FEV1s, and also found that Claimant did not use "continuous maximal effort throughout the forced vital capacity attempt." Dr. Levinson opined that Claimant was "sucking air back in to his lungs in the course of his supposed exhalation." (EX 8) In a report dated May 2, 2001, on review of the original tracings, Dr. Levinson reiterated the opinion summarized above. (EX 10) Dr. Robin Kaplan (Board-certified in Internal Medicine and Pulmonary Disease) also invalidated this study in a report of March 22, 2001. (EX 9) Dr. Kaplan stated that the study

showed "faulty technique" demonstrated by the "slope of the expiratory tracing [...] decreasing during the latter half of each effort, when it should be increasing, or leveling off." He also noted "submaximal and variable effort" as shown by "variation [in the forced tracings] that far exceeds the maximum" allowed by the regulations. (EX 9)

In reports dated April 3, 2001 and June 14, 2001, Dr. Matthew Kraynak (Board-certified in Family Medicine) reviewed the reports of Dr. Levinson and Dr. Kaplan and generally disagreed with their findings, stating that the studies showed good effort and that the FEV1s showed less than 100 ml. variance. (CX 9, 10, 11, 20) I find that Dr. Levinson's and Dr. Kaplan's reports are entitled to more weight, however, because they are better reasoned and detailed, and because these two physicians have superior credentials to those of Dr. Kraynak. The significantly higher values of the January 11, 2001 test, which are practically contemporaneous with this study, support the analysis by Dr. Levinson and Dr. Kaplan that the values on the later study are a result of poor effort. In addition, the February 26, 2001 pulmonary function study included no flow-volume loop as required by the regulations.[7] Based on the foregoing, I find that this pulmonary function study is not valid.

August 14, 2001 Pulmonary Function Study

Dr. Kaplan invalidated the August 14, 2001 pulmonary function study in a report of August 28, 2001. (EX 11) He reported that the study showed "submaximal effort" as indicated by comparing the MVV measurements to the FEV1 measurements. He noted that "with a best effort FEV1.0 of 1.61 liters, the maximum expected MVV [would be] 64.4 liters per minute" and that in this case, the MVV was 75.5 liters "strongly suggest[ing] that the FEV1.0 was the result of a submaximal effort." (EX 11) Dr. Gregory Fino (Board-certified in Internal Medicine and Pulmonary Disease) invalidated this test on September 10, 2001. (EX 12, 16) He wrote that the FVC tracings "show[] a lack of an abrupt onset to exhalation, a hesitancy and inconsistency in expiratory flows, a premature termination to exhalation before 5 seconds, a lack of plateauing in the expiratory curves, a lack of reproducibility in the expiratory curves, and a complete lack of patient effort and cooperation. (EX 12) He also invalidated the MVVs due to a "breathing frequency less than 60 breaths per minute, erratic tidal volumes, and tidal volumes measuring less than 50-60% of the observed forced vital capacity." (EX 12) Finally, in a report of September 5, 2001, Dr. Levinson concluded the forced vital capacity curves showed "marked hesitation in the course of exhalation with various interruptions." (EX 13) He also reported that the flow volume curves showed "discontinuation between inhalation and exhalation" which demonstrates interrupted breathing and that the MVVs indicated a "variable and inconsistent effort." (EX 13)

Dr. Simelaro and Dr. Venditto validated the August 14, 2001 study on September 25, 2001 and October 2, 2001 respectively. (CX 21) Similarly, Dr. David S. Prince (Board-certified in Internal Medicine and Pulmonary Disease) validated this study on November 28, 2001 (exhibit marked as "CX 22"). The latter report exceeds the number of validations I found permissible at the hearing, and therefore,

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[7] Any ventilatory study performed after January 19, 2001 must contain the results of flow versus volume (flow-volume loop) and the FEV_1/FVC ratio must be expressed as a percentage. §§ 718.104(b) and 718.103(a).

I do not consider it here. See supra n. 2. However, even had this last exhibit been received into evidence there would be then be an equal number of validations and invalidations. As it stands, the invalidations outweigh the validations, and the credentials of the physicians who invalidated this report persuade me that the pulmonary function study is not valid and does not accurately represent Claimant's lung function.

The record contains two arterial blood gas studies:

DATE	EX. NO.	PHYSICIAN	pCO2	PO2	QUALIFIES
03/27/01	EX 15	Levinson	37 42*	92 91*	No No*
09/07/00	DX 11	R. Kraynak	42	68	No

*post-exercise

The following physicians rendered opinions in this case: Drs. Langon, Kraynak, Levinson, and Fino. Their respective opinions are summarized below.

In a brief, undated letter, Dr. James P. Langon (Board-certified in Family Practice) reported that he has been Claimant's treating physician since 1992. (CX 14, 15) He reported that he treated Claimant's coronary artery and gout, and noted that Claimant had "complained of problems with shortness of breath" and that he had "pulmonary fibrosis on chest x-ray." Dr. Langon concluded that Claimant's "long history of working around the coal mines" contributed to his pulmonary fibrosis and may have been a factor in his coronary artery disease and subsequent heart attack. Dr. Langon's treatment notes, also of record, give no insight into his reasoning and ultimate diagnosis of coal workers' pneumoconiosis. (DX 24) Despite Dr. Langon's status as Claimant's treating physician, I am not persuaded that his opinion is entitled to "controlling" weight after consideration of the factors of § 718.104(d). First, from his report it appears that Dr. Langon treated Claimant primarily for his non-respiratory conditions (i.e., his coronary artery disease and gout). Also, there is no indication that Dr. Langon obtained "superior and relevant information concerning the miner's condition" in the course of his treatment of Claimant. § 718.104(d)(4). For these reasons, I do not give Dr. Langon's report any weight, let alone controlling weight, as it is not well-reasoned or detailed.[8]

Dr. R. Kraynak examined Claimant on August 23, 2000. (DX 9) In a report dated August 24, 2000, he reported that Claimant had a 55-year coal mine employment history, and "less than 10 pack-year" cigarette smoking history. Upon physical examination of Claimant, Dr. Kraynak noted an increased AP diameter, normal findings on palpation and percussion of Claimant's chest and lungs, and wheezing on auscultation. He reported that Claimant's subjective complaints included daily sputum production and wheezing, coughing, and shortness of breath. Dr. Kraynak reported X-ray evidence of pneumoconiosis (½) and that arterial blood gas studies showed "hypoxemia on room air." Dr. Kraynak diagnosed coal

[8]Even if I found that Dr. Langon's opinion was entitled to weight, as will be discussed below, the opinion is still outweighed by the contrary probative evidence of record. § 718.104(d)(5).

workers' pneumoconiosis due to "coal dust exposure," and "status-post coronary artery bypass graft." (DX 9) In a deposition of May 11, 2001, Dr. Kraynak reiterated his conclusion that Claimant had pneumoconiosis. (CX 12, p.12–13) He also reiterated his disagreement with the invalidations of the August 23, 2000 and the February 26, 2001 pulmonary function studies. (CX 12, p.6–8) Dr. Kraynak testified that he credited the positive X-ray reports over the negative X-ray reports based on Claimant's long history of coal mine employment. (CX 12, p.22) Although I find that Dr. Kraynak's report is more detailed than that of Dr. Langon, the objective data he gathered does not support his conclusion. Dr. Kraynak relied in part on invalid pulmonary studies when diagnosing Claimant, and relied on positive X-ray interpretations of the August 23, 2000 X-ray which were ultimately outweighed by the negative interpretations. Dr. Kraynak also conceded that he is the only physician who found cyanosis or wheezing. Moreover, Dr. Kraynak performed no cardiac testing and acknowledged that Claimant's weight could be the cause of his breathing complaints. (CX 12, p.19–21) These factors diminish the weight to be given Dr. Kraynak's opinion. Although he is Claimant's "treating physician" for purposes of Claimant's pulmonary condition, at the time of his deposition, Dr. Kraynak had treated Claimant for less than a year and had seen him only 3 or 4 times. (CX 12, p.17) I find that these factors certainly weigh against attributing "controlling" weight to Dr. Kraynak's opinion pursuant to § 718.104(d). As it is, for the reasons outlined above, I find that his opinion is entitled to only minimal weight.

Dr. Levinson examined Claimant on January 11, 2001 and reviewed Claimant's medical records. (EX 15) In a report of March 27, 2001 Dr. Levinson reported that Claimant's lungs were clear to percussion and auscultation, and that Claimant's extremities showed no edema, cyanosis, or clubbing. An electrocardiogram showed evidence of left atrial enlargement, occasional premature ventricular contractions, and evidence of prior open heart surgery. Dr. Levinson reported that a chest X-ray showed no evidence of pneumoconiosis. He noted that his January 11, 2001 pulmonary function study showed poor effort, but even with poor effort, only a minor reduction in the vital capacity with normal FEV1. Dr. Levinson reported that the arterial blood gas studies were normal and demonstrated an excellent response to exercise. He concluded that Claimant did not have coal workers' pneumoconiosis, or any "industrial pulmonary disease." (EX 15) Dr. Levinson reported that the October 29, 1998 pulmonary function study was "within normal limits" and again even with poor effort, the current pulmonary function study revealed only a small reduction in vital capacity. He also reported normal arterial blood gas test results. Dr. Levinson found that Claimant's other medical conditions, including prostate problems, hypercholesterolemia, history of coronary bypass, were all unrelated to this coal mine employment. Dr. Levinson found no evidence of pneumoconiosis.

Dr. Levinson also testified in a deposition on April 30, 2001. In regards to his January 11, 2001 pulmonary function study, Dr. Levinson reported that despite Claimant's poor effort, there was improvement in Claimant's FVCs and FEV1s post-bronchodilator. He noted that the MVVs are the most effort-dependent, and the fact that this value showed reduction post-bronchodilator and the FVCs and FEV1s had improved, indicated to him that the variations were "more related to effort rather than...reversibility or improvement related to bronchodilator because it's contradictory." (EX 18, p. 20–21) He reiterated that despite the poor effort, Claimant's pulmonary function study values were still fairly normal. He did not find evidence of pneumoconiosis because Claimant's symptoms were non-specific, there were no abnormalities on physical examination suggestive of coal workers' pneumoconiosis, the chest X-rays were negative, the pulmonary function study results were invalid (but still fairly normal), the arterial

blood gas study values were excellent, and the electrocardiogram testing did not indicate any cardiac condition or impairment related to a lung disorder. (EX 18, p.23–24) I find that Dr. Levinson's report is well-reasoned and entitled to significant weight.

On April 12, 2001, Dr. Gregory Fino (Board-certified in Internal Medicine and Pulmonary Disease) conducted a review of Claimant's medical records. (EX 16) He concluded that Claimant had normal pulmonary function in light of the valid pulmonary functions studies of record—especially in light of Claimant's four vessel coronary bypass surgical graft. Dr. Fino saw no evidence of coal workers' pneumoconiosis, or an "occupationally acquired pulmonary condition." After reviewing additional medical evidence, Dr. Fino stated that his opinion was unchanged. (EX 17) At a deposition of May 18, 2001, Dr. Fino reiterated that the pulmonary function studies performed on February 26, 2001 and August 23, 2000 were invalid due to poor reproducibility and poor effort. (EX 19, 14–17) He also reiterated that Claimant did not have coal workers' pneumoconiosis or an "occupationally-related pulmonary condition," and opined that any shortness of breath was due to coronary artery disease and Claimant's sleep apnea. (EX 19, p.17–18)

The medical evidence also includes records from PennState Geisinger Health System, which document Claimant's treatment for BPH, sleep apnea, exertional angina pectoris, and carpal tunnel syndrome. (DX 24) In addition, records from St. Joseph's Medical Center discuss Claimant's myocardial revascularization in April 2000. (DX 10) Notably, in October 1997, Dr. Joseph A. Cable (qualifications not of record) conducted a nocturnal sleep study because of Claimant's complaints of snoring. At this time, Dr. Cable reported no evidence of cyanosis, clubbing, or edema in Claimant's extremities and he reported that Claimant's lungs showed normal expansion and were clear bilaterally. (DX 24) These hospital records do not support a finding of pneumoconiosis.

The opinion of Dr. Kraynak does not establish the presence of pneumoconiosis as it is significantly outweighed by the contrary opinions of Dr. Levinson and Dr. Fino.[9] As described above, the opinions of Dr. Levinson and Dr. Fino are more thorough in their discussion of laboratory and physical examination findings and the miner's medical history, in contrast to that of Dr. Kraynak. In addition, Dr. Levinson and Dr. Fino have superior credentials. Therefore, I find that the opinions of Dr. Levinson and Dr. Fino outweigh that of Dr. Kraynak.

In conclusion, I find that the physicians' opinion evidence does not support a finding of the presence of pneumoconiosis. §718.202(a)(4).

Considering all the medical evidence together pursuant to § 718.202(a), I find that Claimant has failed to establish the presence of pneumoconiosis.

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[9]As described above, Dr. Langon's report is flawed and entitled to no weight. Moreover, had this opinion been entitled to some weight, because of their superior credentials, Dr. Levinson's and Dr. Fino's respective opinions are of significantly more weight.

2. Pneumoconiosis Due to Coal Mine Employment

Assuming *arguendo* that Claimant had established the presence of pneumoconiosis, he must also establish that his pneumoconiosis arose at least in part out of coal mine employment. Miners with a coal mining history of at least 10 years benefit from a rebuttable presumption that the pneumoconiosis arose out of such employment. § 718.203. In the instant case, Claimant has established 43 years of coal mine employment and, therefore, the presumption would have been invoked. Employer presented no evidence to contradict such a presumption. As noted above, however, Claimant has not established the presence of pneumoconiosis.

Based on the foregoing, Claimant has not established this element of entitlement.

3. Total Disability

Claimant must first establish that he is totally disabled due to a respiratory or pulmonary condition. Total disability is defined in § 718.204(b)(1) as follows:

> [A] miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner (i) From performing his or her usual coal mine work; and (ii) From engaging in [other] gainful employment in a mine or mines ... .

Nonpulmonary and nonrespiratory conditions which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" have no bearing on total disability under the Act. § 718.204(a); see also Beatty v. Danri Corp., 16 BLR 1-1 (1991), aff'd as Beatty v. Danri Corp. & Triangle Enterprises, 49 F.3d 993, 1000 (3d Cir. 1995). However, revised § 718.204(a) further provides:

> If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition shall be considered in determining whether the miner was totally disabled [under the Act].

Section 718.204(b)(2) sets forth the criteria for establishing total disability. A presumption of total disability is not established by a showing of evidence qualifying under a subsection of § 718.204(c), but rather such evidence shall establish total disability in the absence of contrary evidence of greater weight. Gee v. W.G. Moore & Sons, 9 BLR 1-4 (1986). All medical evidence relevant to the question of total disability must be weighed, like and unlike together, with Claimant bearing the burden of establishing total disability by a preponderance of the evidence. Rafferty v. Jones & Laughlin Steel Corp., 9 BLR 1-231 (1987).

Claimant may establish total disability in one of four ways: pulmonary function study; arterial blood gas study; evidence of cor pulmonale with right sided congestive heart failure; or reasoned medical opinion. § 718.204(c)(1)–(4) and § 718.204(b)(2)(i)–(iv).

In order to establish total disability through pulmonary function tests, (ie., by "qualifying" tests) the FEV_1 must be equal to or less than the values listed in Table B1 (males) or Table B2 (females) of Appendix B to this part and, in addition, the tests must also reveal either: (1) values equal to or less than those listed in Table B3 (males) or Table B4 (females) for the FVC test, or (2) values equal to or less than those listed in Table B5 (males) or Table B6 (females) for the MVV test or, (3) a percentage of 55 or less when the results of the FEV_1 test are divided by the results of the FVC tests. § 718.204(c)(1)(i)–(iii) and § 718.204 (b)(2)(i)(A)–(C). Assessment of pulmonary function study results are dependent on Claimant's height, which was recorded most frequently as 72 inches. I used that height in evaluating the studies. Protopappas v. Director, 6 BLR 1-221 (1983).

As outlined above, I found that the three pulmonary function studies that yielded qualifying results were invalid. Therefore, the pulmonary function study evidence is not sufficient to establish total disability under the provisions of § 718.204(b)(2)(i).

None of the arterial gas studies yielded qualifying results. Claimant has not established total disability under the provisions of § 718.204(b)(2)(ii).

Under § 718.204(b)(2)(iii), total disability can also be established where the miner had pneumoconiosis and the medical evidence shows that he suffers from cor pulmonale with right-sided congestive heart failure. There is no record evidence of cor pulmonale with right-sided congestive heart failure.

The remaining means of establishing total disability is with the reasoned medical judgment of a physician that Claimant's respiratory or pulmonary condition prevents him from engaging in his ususal coal mine work or comparable and gainful work. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv).

In his undated report, Dr. Langon concluded that Claimant was permanently and totally disabled and that "Black Lung is a significant underlying cause." (CX 14) This opinion is not entitled to any weight, as there is no reasoning provided for its conclusion.

In his report of August 24, 2000, Dr. Kraynak concluded that Claimant had a "severe" impairment and that he could not perform his previous coal mine employment. Dr. Kraynak also found that Claimant's carpal tunnel syndrome was also disabling. (DX 9) In his deposition testimony, Dr .Kraynak reiterated this conclusion. (CX 12, p.12–13) Dr. Kraynak's opinion was based on his work, social, and medical histories; subjective complaints; review of medical records; physical examination; and clinical studies. (CX 12, p.12)

In his written report, Dr. Levinson concluded that from a pulmonary standpoint, the miner could perform his previous coal mine employment. Specifically, Dr. Levinson reported that Claimant's "residual pulmonary capacities [would allow him] to perform work similar to his previous work in the coal mining industry." (EX 15) In his deposition of April 30, 2001, Dr. Levinson reiterated his conclusion that Claimant has no disability due to coal workers' pneumoconiosis nor any related pulmonary condition. (EX 18, p.24-25) He based his opinion on the fact that the pulmonary function studies demonstrated a "substantial

retention of pulmonary function capacity," and that arterial blood gasses showed "no substantial decline or impairment that would indicate that [Claimant] has...a limitation in his oxygenation." Finally, Dr. Levinson also noted that his physical examination of Claimant showed no pulmonary impairment. (EX 18, p.24–25)

Dr. Fino saw no evidence of a respiratory or pulmonary disability and reported that from a respiratory standpoint, Claimant could perform his last coal mine work or a "job requiring similar effort." (EX 16) After reviewing additional medical evidence, Dr. Fino reiterated his opinion that Claimant's disability is due to coronary artery disease and that he has no evidence of disability from lung disease. Dr. Fino noted that the pulmonary function study of August 23, 2000 was invalid. (EX 17) He also wrote that "even if I had assumed the presence of coal workers' pneumoconiosis, it would have played no role in his disability." In his deposition of May 18, 2001, Dr. Fino explained that the basis for his conclusion was that the October 28, 1998 pulmonary function study showed that Claimant had "no difficulty getting air into or out of his lungs." (EX 19, p.11) He also stated that "the valid objective lung function studies show no impairment, Dr. Levinson's FEV1 from 2001 shows no impairment, and the exercise study performed by Dr. Levinson shows no drop in the PO2 with exercise." (EX 19, p.17)

For reasons similar to those set forth above, I find the opinions of Dr. Levinson and Dr. Fino to be the most persuasive. In particular, their conclusions regarding Claimant's pulmonary capacity are well supported by the results of the conforming laboratory studies. In addition, their qualifications are superior to those of Dr. Kraynak. Based on the thorough, well-reasoned, and well-supported medical opinions of Drs. Levinson and Fino, I find that Claimant has not established total disability under the provisions of § 718.204(b)(2)(iv).

Based on the foregoing, on consideration of all of the evidence, like and unlike, I find that Claimant has not established total disability under § 718.204(b).

4. Total Disability

Assuming *arguendo* that Claimant had proven total disability, there is insufficient evidence that this total disability arose out of a pneumoconiosis. The reasons for attributing more weight to the opinions of Dr. Levinson and Dr. Fino apply to this issue and outweigh the opinion of Dr. Kraynak.

Based on the foregoing, Claimant has not established this element of entitlement.

E. Conclusion

As Claimant has failed to establish any elements of entitlement, he is not entitled to benefits and his claim for benefits under the Act must be denied.

ATTORNEY FEE

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

ORDER

The claim of CLARENCE F. POLUKIS for benefits under the Act is DENIED.

A

Robert D. Kaplan
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this notice must also be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.